

If no specific allocation of a lump sum payment is made, we will assume the total payment is an Other Income Benefit.

*Assumed Receipt of Benefits*

We will assume you or your dependents, if applicable, are receiving Other Income Benefits if you are eligible to receive them. We will estimate the amount of these assumed benefits on the basis of what you may be eligible to receive.

We will not assume your receipt of Other Income Benefits if you give us proof of the following events.

1. Application was made for these benefits.
2. Reimbursement Agreement is signed by you.
3. Any and all appeals were made for these benefits, or we have determined further appeals will not be successful.
4. Payments were denied.

We will not assume you have received, nor will we reduce your Disability Benefits by, any elective, actuarially reduced, or early retirement benefits under such laws until you actually receive them.

*Social Security Assistance*

We will, at our own discretion, assist you in applying for Social Security Disability Income (SSDI) benefits. Disability Benefits will not be reduced by your assumed receipt of SSDI benefits while you participate in the Social Security Assistance Program.

We may require you to file an appeal if we believe a reversal of a prior decision is possible. If you refuse to participate in, or cooperate with, the Social Security Assistance Program, we will assume receipt of SSDI benefits until you give us proof that you have exhausted all the administrative remedies available to you.

**Minimum Benefit**

We will pay the Minimum Benefit regardless of any reductions made for Other Income Benefits. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment.

**Recovery of Overpayment**

If we overpay your benefits, we have the right to recover the amount overpaid by either requesting you to pay the overpaid amount in a lump sum or by reducing any amounts payable to you by the amount due. If there is an overpayment due when you die, we will reduce any benefits payable under the Policy to recover the overpayment.

TY-005183-1

#### **ADDITIONAL BENEFITS**

**Rehabilitation During a Period of Disability**

If we determine that you are a suitable candidate for rehabilitation, we may require you to participate in a Rehabilitation Plan. We have the sole discretion to approve your participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan.

The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

If you fail to fully cooperate in all required phases of the Rehabilitation Plan without Good Cause, no Disability Benefits will be paid, and insurance will end.

TY-005189-1

#### **Conversion Privilege**

If your insurance ends because you are no longer employed by the Employer, or you are laid off or on an uninsured leave of absence, you may be eligible for long term disability conversion insurance. To be eligible, you must have been insured for Disability Benefits and actively at work for at least 12 months. You must apply for conversion insurance within 62 days after your insurance ends.

The benefits of the conversion plan will be those benefits offered at the time you apply. The premium will be based on the rates in effect for conversion plans at that time.

You may not convert your insurance if any of the following conditions apply to you.

1. You are retired or age 70 or older.
2. You are not in Active Service because of Disability.
3. The Policy is canceled for any reason.
4. You are no longer in a Class of Eligible Persons, but are still employed by the Employer.

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#### **Survivor Benefit**

We will pay a Survivor Benefit if you die while Disability Benefits are payable and at least 6 Monthly Benefits have been payable to you for a continuous period of Disability. The Survivor Benefit will equal 100% of the sum of the last full Disability Benefit payable to you plus any current earnings by which the Disability Benefit was reduced for that month. A single lump sum payment equal to 6 monthly Survivor Benefits will be payable.

Benefits will be paid according to the *To Whom Payable* section of the *Claim Provisions*.

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#### **WHAT IS NOT COVERED**

We will not pay any Disability Benefits for a Disability that results, indirectly or directly, from:

1. suicide, attempted suicide, or self-inflicted injury.
2. war or any act of war, whether or not declared.
3. an Injury or Sickness that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. An Injury or Sickness that occurs while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.

We will not pay Disability Benefits for a Disability that results directly from the commission of a felony or attempted felony.

We will not pay Disability Benefits for any period of Disability during which you:

4. are incarcerated in a penal or corrections institution.
5. are not receiving Appropriate Care.

6. fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit due.
7. refuse to participate in rehabilitation efforts as required by us.

TY-005177-1

## **CLAIM PROVISIONS**

### **Notice of Claim**

Written notice or notice by any other electronic or telephonic means authorized by us, must be given to us after a covered loss occurs or begins, or as soon as reasonably possible. If this notice is not given within a reasonable amount of time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Written notice can be given at our home office in New York, New York or to our agent. Notice should include the Policyholder's name and policy number and the Insured's name and address.

### **Claim Forms**

When we receive the notice of claim, we will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof or proof by any other electronic or telephonic means authorized by us, of the nature and extent of the loss.

### **Claimant Cooperation Provision**

If you fail to cooperate with us in our administration of your claim, we may terminate the claim. A claimant will be required to provide any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

### **Insurance Data**

The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable laws.

### **Proof of Loss**

Written proof, or proof by any other electronic/telephonic means authorized by us, that Disability continues and of Appropriate Care by, or regular attendance by a Physician must be given to us at intervals required by us. Within 30 days of a request, such proof of continued Disability must be furnished to us.

We will not deny or reduce any claim if it: 1) is not reasonably possible to furnish the required proof within that period; and 2) is shown that such proof of loss was given as soon as was reasonably possible.

### **Time of Payment**

Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.

### **To Whom Payable**

Any benefits that are payable for Disability will be paid to you. If any person to whom benefits are payable is a minor or, in our opinion, is not able to give a valid receipt, such payment will be made to their legal guardian.

If you die while any Disability Benefits remain unpaid, we may, at our option, make direct payment to the first surviving class of the following living relatives: spouse, children, parents, brothers and sisters; or to the executors or administrators of your estate. We may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release us from all liability for any payment made.

**Physical Examination and Autopsy**

We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

**Legal Actions**

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic or telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

**Time Limitations**

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

**Physician/Patient Relationship**

You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

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## **ADMINISTRATIVE PROVISIONS**

**Premiums**

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

**Your Grace Period**

If your required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

**Reinstatement of Insurance**

Your insurance may be reinstated if your insurance ends because you are on an unpaid leave of absence, refuse to participate in rehabilitation efforts, or are not receiving Appropriate Care.

Your insurance may be reinstated only if reinstatement occurs within 6 months from the date your insurance ends. For your insurance to be reinstated all of the following conditions must be met.

1. You must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. A written request, or a request by any other telephonic or electronic means authorized by the Employer and the Insurance Company, for reinstatement must be received by us within 31 days from the date you return to Active Service.
4. The Insurability Requirement, if any, is satisfied.

Your reinstated insurance is effective on the date you return to Active Service if the required premium is paid. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation before your insurance ended, you will receive credit for any time that was satisfied.

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## GENERAL PROVISIONS

### **Entire Contract**

The Policy, the application of the Policyholder (a copy of which is attached at issue), the Policyholder endorsements, riders, certificate and attached papers constitute the entire contract between the parties. If an application of any Employee is required, it may also be made a part of this contract, at our option. Nothing in this Policy will invalidate or impair the rights granted to any certificateholders by their certificates or by law.

### **Incontestability**

All statements made by the Policyholder, or by an Employee are deemed representations and not warranties. No statement will cause us to deny or reduce benefits or be used as a defense to a claim, unless a copy of the written instrument, signed by the claimant, containing the statement is, or has been, furnished to such person while such person is still living. In the event of his death or legal incapacity, the beneficiary or representative must receive a copy. After two years from the Employee's effective date of insurance, no such statement will cause insurance to be contested except for non-payment of premium. This also applies to any added or increased benefits, from the effective date of the addition or increase in benefits.

### **Misstatement of Age**

If your age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

### **Workers' Compensation Insurance**

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance.

### **Assignment**

The Insurance Company will not be affected by any assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. We do not assume responsibility for the validity or sufficiency of an assignment. An assignment of the certificate will operate so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment will transfer all rights and obligations of the Insured, or of the owner if other than the Employee.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts. This prohibition does not apply where it is contrary to law.

### **Conformity with State Statutes**

Any provision of the Policy in conflict on the Policy Effective Date with the laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such laws.

### **Male Pronoun**

The male pronoun as used herein will be deemed to include the female.

### **Clerical Error**

Your coverage will not be affected by error or delay in keeping records of insurance under the Policy. If such an error or delay is found, the premium will be adjusted fairly.

### **Agency**

The Policyholder, Employer and plan administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

## **DEFINITIONS**

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

### **Active Service**

If you are an Employee, you are in Active Service on a day which is one of your Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time or Part-time (if applicable) basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence.

You are in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

### **Annual Enrollment Period**

The period in each calendar year agreed upon by your Employer and us when you may enroll for, or change benefit elections, under the Policy.

### **Appropriate Care**

Appropriate Care means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of your Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

### **Consumer Price Index (CPI-W)**

The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor.

### **Covered Earnings**

Covered Earnings means your annual wage or salary as reported by the Employer for work performed for the Employer as in effect on the October 1 just prior to the date your Disability begins, plus the greater of a) the prior year's commissions and/or bonus paid through September 30 or b) commissions and/or bonus paid 2 years prior. Covered Earnings are determined initially on the date an Employee applies for coverage.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

### **Disability/Disabled**

For purposes of coverage under the Policy, you will be considered Disabled if, because of Injury or Sickness, you are unable to perform the material duties of your regular occupation, or solely due to Injury or Sickness, you are unable to earn more than 80% of your Indexed Covered Earnings.

After Disability Benefits have been payable for 24 months, you will be considered Disabled if your Injury or Sickness makes you unable to perform the material duties of any occupation for which you may reasonably become qualified based on education, training or experience, or solely due to Injury or Sickness, you are unable to earn more than 80% of your Indexed Covered Earnings.

**Employee**

For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

**Employer**

The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

**Full-time**

Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

**Good Cause**

A medical reason preventing participation in the Rehabilitation Plan or in a Transitional Work Arrangement. Satisfactory proof of Good Cause must be provided to us.

**Indexed Covered Earnings**

For the first year you are Disabled, your Indexed Covered Earnings will be equal to your Covered Earnings. After you have been Disabled for 1 year, your Indexed Covered Earnings will be your Covered Earnings plus an increase applied on each annual anniversary of the date you became Disabled. The amount of each increase will be the lesser of:

1. 10% of your Indexed Covered Earnings during the preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

**Injury**

Any bodily harm, including all related conditions and recurring symptoms of the injuries, that results directly or indirectly from an Accident and independently of all other causes.

**Insurability Requirement**

You will be considered to have satisfied the Insurability Requirement on the day we agree in writing to accept you as covered under the Policy. To determine a person's acceptability for insurance, we will require evidence of good health and may require it be provided at your own expense.

**Insurance Company**

The Insurance Company underwriting the Policy is CIGNA Life Insurance Company of New York. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

**Insured**

You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, any applicable Insurability Requirement is met, the required premium is paid and your insurance is in force under the Policy.

**Life Status Change**

A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

If the Employer does not sponsor a Flexible Benefits Plan or if it is no longer in effect, the following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child

4. Death of your spouse
5. Termination of your spouse's employment
6. A change in the benefit plan available to your spouse
7. A change in employment status for you or your spouse that affects your eligibility for benefits

**Part-time**

Part-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

**Physician**

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings or spouses of any of the foregoing, whether related by blood or marriage) of either you or your spouse, or a person living in your household.

**Policy Anniversary**

A Policy Anniversary is the date so stated on the Policy cover and the same date that follows every 12 months for as long as the Policy is in effect.

**Policy Effective Date**

The Policy Effective Date is the date so stated on the Policy cover.

**Prior Plan**

The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date.

**Sickness**

The term Sickness means a physical or mental illness. It also includes pregnancy.

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**SUPPLEMENTAL INFORMATION  
for**

**Employee Protection Plan ("Signature Benefits")**

**required by the Employee Retirement  
Income Security Act of 1974**

As a Plan participant in Bertelsmann, Inc.'s Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

**IMPORTANT INFORMATION ABOUT THE PLAN**

- The Plan is established and maintained by Bertelsmann, Inc., the Plan Sponsor.
- The Employer Identification Number (EIN) is 95-2949493.
- The Plan Number is 503.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, NYK-980002, issued by CIGNA LIFE INSURANCE COMPANY OF NEW YORK.
- The Plan Administrator is:      Welfare Benefit Plan Committee c/o Bertelsmann, Inc.  
    1540 Broadway  
    New York, NY 10036

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by Company contributions and Employee contributions.
- The date of the end of the Plan Year is June 30.

**WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM**

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. You must complete your claim according to directions provided by the Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company's written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.

#### **Appeal Procedure for Denied Claims**

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (or 45 days, in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

### **YOUR RIGHTS AS SET FORTH BY ERISA**

As a participant in Bertelsmann, Inc.'s Insurance Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

#### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

#### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

#### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

**IMPORTANT CHANGES FOR STATE REQUIREMENTS**

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state, and only when the underlying provision is included in the certificate.

**Louisiana residents:**

The percentage of Covered Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

**Minnesota residents:**

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

**Texas residents:**

Any provision offsetting or otherwise reducing any benefit by an amount payable under an individual or franchise policy will not apply.